DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/22/12

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445235	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE REHABILITATION AND NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to determine safety of self administration of drugs for one resident (#139) of thirty-six residents reviewed. The findings included: Resident #139 was admitted to the facility on February 28, 2012, with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety, Hypertension, Bipolar Disorder, and Atrial Fibrillation. Medical record review of a Self Administration of Medications assessment dated February 29, 2012, revealed "...not applicable...has limited desire to self medicate..." Medical record review of a Physician Order dated February 28, 2012, revealed "...(Duo Neb) (prevent bronchospasm) pratropium-Albuterol 0.5 MG (milligram) /3 ML (milliliter) -2.5 (3) MG/3 ML Solution inhalation 3 ml q (every) 4 h (hours) while awake..." Facility policy review of Self-Administration of Medications by Residents (no date) revealed "...if	F 176	**1. Corrective action for residents affected:** Self administration assessment was completed by nursing on resident #139 on 3/06/12 finding the resident competent to self administer. **2. Identification of others who could be affected by the deficient practice:** All residents receiving nebulizer treatments have the potential to be affected by this practice. **3. Measures put in place to ensure deficient practice does not reoccur:** The Nurse Educator completed an inservice of nursing regarding self administration policy on 3/23/12, new staff to be educated during the orientation process.	3/06/12 3/06/12 3/23/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra R. Tucker — TITLE: Administrator — (X6) DATE: 3/22/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 the resident indicates no desire to self-medicate medications this is documented...the interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment..." Observation on March 5, 2012, at 10:09 a.m., in the resident's room, revealed the resident self administering a hand held nebulizer treatment. Observation on March 5, 2012, at 10:12 a.m., in the resident's room, revealed Registered Nurse (RN) #1 entered the room and stated, "I think it is done." Interview with the Assistant Director of Nursing (ADON) on March 6, 2012, at 4:30 p.m., in the conference room, confirmed the resident was not a candidate for self administration and had not been assessed by the interdisciplinary team for self-administration of medications.	F 176	**4. Systems to monitor the effectiveness:** a.) Random audits of nebulizer administration for compliance will be completed by Unit Managers and/or Team Leaders on two residents weekly x4 weeks and then monthly thereafter, with re-education as necessary by the Unit Manager. b.) Findings will be reported monthly by the Unit Manager and/or Team Leader to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	4/08/12 4/08/12
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225	**1. Corrective action for residents affected:** Allegation of abuse involving resident #37 was reported to the State Department of Health by the Administrator. **2. Identification of others who could be affected by the deficient practice:** Facility conducted an audit of state reportable incidents for last 6 months by the Administrator for compliance.	12/6/11 3/ 8/11

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F 225	Continued From page 2 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, review of facility policy, and interview, the facility failed to submit a written report of an allegation of abuse to the State Department of Health within working five days for one resident report (#37) of three reports reviewed. The findings included: Review of facility documentation dated December 6, 2011, revealed Resident #37 reported an allegation of physical abuse on November 18, 2011, and the facility reported the allegation to	F 225	**3. Measures put in place to ensure deficient practice does not reoccur:** a.) Nurse Educator in-serviced Administrator, DON, and Social Services Director regarding State requirements for reporting unusual incidents. 3/9/12 b.) Unusual incidents will be discussed during daily clinical meeting and noted on daily communication sheet for duration of investigation. 3/09/12 **4. Systems to monitor the effectiveness:** a.) Social services director will audit UIRS on working day 5 after unusual incident occurs for compliance. Deficiencies will be reported to facility administrator. 3/09/12 b.) Findings will be reported monthly by the Social Services Director to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager. 3/09/12	

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F 225	Continued From page 3 the State Department of Health on December 6, 2011, eighteen days after the reported allegation of physical abuse. Review of facility policy, Abuse Prevention, reviewed October 1, 2011, revealed "...a written report must be submitted within five (5) days...to Department of Health...any violation of this policy may result in disciplinary action up to termination..." Interview with the Nursing Home Administrator on March 8, 2012, at 2:55 p.m., in the Director of Nursing Office, confirmed the facility failed to submit a written report of an allegation of physical abuse to the State Department of Health within five working days resulting in an eighteen day delay in reporting.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to promote care that maintained or enhanced dignity for two residents (#5, #51) of thirty-six residents reviewed. The findings included: Resident #5 was admitted to the facility on	F 241	**1. Corrective action for residents affected:** a.) Privacy bag was placed over the catheter bag of resident #5 by nursing. b.) Privacy curtain of resident #51 was pulled by nursing. **2. Identification of others who could be affected by the deficient practice:** a.) Residents with indwelling catheters audited for presence of dignity bag by nursing. b.) All residents have the potential to be affected by this practice.	3/08/12 3/08/12 3/08/12

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F 241	Continued From page 4 January 20, 2012, with diagnoses including Dementia, Neurogenic Bladder, Depression, Atrial Fibrillation and Failure to Thrive. Observation on March 5, 2012, at 10:35 a.m., in the resident's room, revealed the resident sitting in the wheelchair, the foley catheter bag hanging on the arm of the wheelchair, and the foley tubing cloudy with dark colored urine. Observation on March 5, 2012, at 11:39 a.m., in the Restorative Dining Room, revealed the resident eating lunch and the foley catheter bag attached to the bottom of the wheelchair on the floor with no privacy bag covering the Foley catheter bag. Interview with the C-Wing Assistant Director of Nursing (ADON) on March 5, 2012, at 2:00 p.m., in the C-Wing Nurse's Station confirmed the foley catheter was not covered with a privacy bag, was on the floor, and did not promote care that maintained dignity for the resident. Resident #51 was readmitted to the facility on January 12, 2012, with diagnoses including Atrial Fibrillation, Pneumonia, Anemia, and Open Wound. Medical record review of the Minimum Data Set (MDS) dated February 1, 2012, revealed the resident was independent for daily decision making. Observation on March 7, 2012, at 7:49 a.m., in the resident's room, revealed the resident lying on the bed with the privacy curtain not pulled between the resident and the roommate.	F 241	**3. Measures put in place to ensure deficient practice does not reoccur:** a.) The Nurse Educator completed an inservice to nursing staff regarding resident dignity on 3/23/12, new staff to be inserviced during the orientation process. b.) Social Services Director completed an in-service to staff regarding Resident Rights on 3/23/12, new staff to be inserviced during the orientation process. **4. Systems to monitor the effectiveness:** a.) Residents with indwelling catheters will be audited by Unit Manager for presence of dignity bag three times weekly x4 weeks and monthly thereafter with corrective action as necessary by the Unit Manager. b.) Resident interviews will be conducted regarding self determination by Social services director/designee on 3 residents weekly x4 weeks and monthly thereafter with corrective action as necessary by the DON. c.) Findings will be reported monthly by the Unit Manager, Social Services Director to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	3/23/12 3/23/12 4/08/12 4/08/12 4/08/12

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F 241	Continued From page 5 Interview with the resident on March 7, 2012, at 7:49 a.m., in the resident's room confirmed last night the resident requested the privacy curtain be pulled between the resident and the roommate, the staff refused, and this morning the staff had refused to pull the privacy curtain. Interview with the C-Wing ADON on March 7, 2012, at 7:55 a.m., in the C-Wing Nurse's Station, confirmed the resident had requested the privacy curtain be pulled between the resident and the roommate. Further interview at this time confirmed the staff did not pull the privacy curtain last night, and the curtain was not pulled at this time due to the staff needed to view the roommate when the staff was in the hall. Interview with the Director of Nursing (DON) on March 7, 2012, at 8:25 a.m., in the DON office, confirmed the staff not pulling the privacy curtain as the resident requested did not maintain the resident's dignity and respect the residents individuality.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278	**1. Corrective action for residents affected:** MDS assessment for Resident #5 was corrected to accurately reflect falls by MDS nurse. **2. Identification of others who could be affected by the deficient practice:** MDSC completed an audit of all current residents' last assessment for accurate coding of falls by 3/30/12.	3/07/12 3/30/12

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F 278	Continued From page 6 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Minimum Data Set (MDS) was accurate for one resident (#5) of thirty-six residents reviewed. The findings included: Resident #5 was admitted to the facility on January 20, 2012, with diagnoses including Dementia, Neurogenic Bladder, Depression, Atrial Fibrillation and Failure to Thrive. Medical record review of the Minimum Data Set (MDS) dated January 27, 2012, revealed the resident had no falls since admission or prior assessment. Medical record review of a Nurse's Note dated	F 278	**3. Measures put in place to ensure deficient practice does not reoccur:** The Nurse Educator educated MDSC and MDS nurse regarding accurate coding of MDS assessments on 3/09/12. **4. Systems to monitor the effectiveness:** a.) DON to audit for accurate coding of falls on 1 MDS assessment weekly x4 weeks and monthly thereafter for compliance. b.) Findings will be reported monthly by the MDSC and DON to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	3/09/12 4/08/12 4/08/12

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F 278	Continued From page 7 January 24, 2012, at 4:30 p.m., revealed the resident was found on the floor with bruising to the lower spine. Interview with MDS Coordinator #1 on March 7, 2012, at 4:00 p.m., in the MDS Office, confirmed the MDS dated January 27, 2012, did not reflect the fall the resident had experienced on January 24, 2012, and confirmed the MDS was inaccurate.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to follow physician's orders for two resident's (#2, #140) of thirty-six residents reviewed. The findings included: Resident #2 was readmitted to the facility on December 20, 2012, with diagnoses including Atrial Fibrillation, Congestive Heart Failure, Xerophthalmia (extremely dry eyes), and Ocular Hypertension. Medical record review of the Physician's Recapitulation Orders dated March 2012 revealed "...Optive (dry eye) (eye ointment) 0.5% -0.9% Solution Ophthalmic 1 drop (both) to eye (s) q.i.d (four times a day) not to be given with	F 281	**1. Corrective action for residents affected:** a.) RN #2 in-serviced regarding administration of eye drops by nurse educator on 3/08/12. — 3/08/12 b.) Blood pressure of resident #140 obtained by nursing on 3/07/12, parameters for prn antihypertensive not met. — 3/07/12 c.) Water pitcher removed from room of resident #140 by nursing. — 3/08/12 **2. Identification of others who could be affected by the deficient practice:** a.) All residents receiving ophthalmic medications have the potential to be affected by this practice. b.) All residents receiving prn antihypertensive have the potential to be affected by this practice. c.) Room audit of all residents receiving fluid restrictions completed on 3/08/12 by DON/ADON/Unit Managers for absence of water pitchers and found to be compliant. — 3/08/12	

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F 281	Continued From page 8 Azopt (ocular hypertension)..." Review of information provided by the facility dated March 8, 2012, revealed "...Optive Opthalmic use...wait at least five minutes before applying other medications...use eye drops before eye ointments to allow the eye drops to enter the eye..." Observation on March 5, 2012 at 1:57 p.m., in the resident's room, revealed Registered Nurse (RN) #2 administered Optive 0.5%-0.9% solution ophthalmic to the resident's eyes waiting twenty seconds and administered Azopt 1% suspension to the resident's eyes. Interview with RN #2 on March 8, 2012, at 8:31 a.m., in the C-Wing Nurse's Station, confirmed the Optive and Azopt eye drops were administered twenty seconds apart and the Medication Administration Record instructions are the eye drops were not to be given together. Interview on March 8, 2012, at 9:30 a.m., with the Director of Nursing in the conference room, confirmed the eye drops are not to be given together due to absorption and the facility failed to follow the physician's order. Resident #140 was admitted to the facility on February 28, 2012, with diagnoses including End Stage Renal Disease, Weakness, Congestive Heart Failure, and Anxiety. Medical record review of the Physician's Recapitulation Orders dated March 2012 revealed "...Clonidine HCl (medication for hypertension) 0.1 mg (milligram) Tablet by mouth	F 281	**3. Measures put in place to ensure deficient practice does not reoccur:** a.) The Nurse Educator completed education to nursing on administration of ophthalmic medications on 3/23/12, new staff to be educated during the orientation process. b.) The Nurse Educator completed education to nursing on following MD orders on 3/23/12, new staff to be educated during the orientation process. c.) The Nurse Educator completed education to nursing regarding fluid restrictions on 3/23/12, new staff to be educated during the orientation process.	3/23/12 3/23/12 3/23/12

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F 281	Continued From page 9 q (every) 2 h (hour) p.r.n. (as needed) if systolic bp (blood pressure) greater than 170 or diastolic bp greater then 90 do not exceed 6 doses in 24 hours first date: 02/28/2012 for hypertension..." Medical record review of the Nurse's Note dated March 3, 2012, at 10:28 p.m., revealed "...blood pressure: 171/56...", March 5, 2012, at 2:04 a.m., revealed "...Blood Pressure: 183/40...", and March 6, 2012, at 3:45 p.m., revealed "...Blood Pressure: 155/96..." Medical record review of the Medication Administration Record dated March 2012 revealed no Clonidine HCl 0.1 mg had been administered in the month of March. Interview with the C-Wing Assistant Director of Nursing (ADON) on March 7, 2012, at 9:30 a.m., in the C-Wing Nurse's Station, confirmed the blood pressure was 155/96 on March 6, 2012, and confirmed the Clonidine was not administered. Interview with the DON on March 7, 2012, at 9:45 a.m., in the C-Wing Nurse's Station, confirmed the Physician's Orders were not followed by not administering the Clonidine 0.1 mg when the systolic blood pressure was above 170 and the diastolic blood pressure above 90. Medical record review of the Physician's Recapitulation Orders for resident #140 dated March 2012, revealed "...Fluid restriction 1500 cc (cubic centimeters) /24 hour...Dietary to provide 1080 cc...Nursing to provide 360 cc...Free fluid 60 cc..."	F 281	**4. Systems to monitor the effectiveness:** a.) Unit Managers/Team Leaders to complete med pass observation on one resident weekly per unit x4 weeks, then 2x/month thereafter with re-education as needed by Unit Manager/Team Leader. **b.)** Unit Managers/Team leaders to audit 2 resident's receiving prn antihypertensive medications for administration within parameters twice weekly x4 weeks and monthly thereafter with re-education as needed by the Unit Manager/Team Leader. **c.)** Findings will be reported monthly by the Unit Managers/Team Leaders to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	4/08/12 4/08/12 4/08/12

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	445235	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 10 Review of facility policy, Fluid Restriction, dated revised 2010, revealed "...resident's water pitcher should be removed from the resident's room whenever he/she is on a fluid restriction..." Observation on March 7, 2012, at 8:07 a.m., in the resident's room, revealed a clear water pitcher labeled 300 cc with ice and water full. Interview with Certified Nurse Aide (CNA) #1 on March 7, 2012, at 8:12 a.m., confirmed the resident was on fluid restrictions and had a full water pitcher on the resident's bedside table. Further interview at this time confirmed an umbrella (picture) on the resident's door indicating fluid restrictions. Interview with the DON, in the conference room, on March 7, 2012, at 8:53 a.m., revealed water pitchers are to be removed from the resident's room for resident's on fluid restrictions. Further interview at this time confirmed the facility failed to follow fluid restrictions for resident #140.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314	**1. Corrective action for residents affected:** a.) Skin Assessment completed on resident #5 by nursing. b.) Bilateral heels of resident #5 floated by nursing. c.) In-service education provided to C.N.A. #1 by Restorative Manager regarding pressure offloading to bilateral heels **2. Identification of others who could be affected by the deficient practice:** All residents have the potential to be affected by this practice.	3/08/12 3/07/12 3/07/12

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F 314	Continued From page 11 by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to prevent pressure sore development for one resident (#5) resulting in harm to the resident of thirty-six residents reviewed. The findings included: Resident #5 was admitted to the facility on January 20, 2012, with diagnoses including Dementia, Neurogenic Bladder, Depression, Atrial Fibrillation, and Failure to Thrive. Medical record review of the Minimum Data Set (MDS) dated January 27, 2012, revealed the resident was at risk for developing pressure ulcers, required extensive assistance for bed mobility, transfer, and toilet use. Medical record review of the Initial Nursing Skin Assessment dated January 20, 2012, revealed no problems were noted on bilateral heels. Medical record review of a Nurse's Note dated January 20, 2012, at 5:09 p.m., revealed "...General Skin Condition: no problems noted...Foot Problem/Care: has had no foot problems or care in the past 7 days..." Medical record review of the Pressure Sore Risk Assessment dated January 22, 2012, revealed "...Total Score: 12...High Risk 8 or above..." Medical record review of the Care Area Assessment (CAA) dated January 27, 2012, revealed "...resident requires staff assistance to move sufficiently to relieve pressure over any one	F 314	**3. Measures put in place to ensure deficient practice does not reoccur:** a.) The Nurse Educator completed education to nursing on weekly skin assessment and documentation by 3/23/12, new staff to be educated during the orientation process. b.) The Restorative Manager completed education to nursing on 3/30/12 regarding pressure offloading to bilateral heels. **4. Systems to monitor the effectiveness:** a.) DON and/or designee to audit ECS documentation for weekly skin assessments weekly x4 weeks, then 2x/month thereafter with re-education as needed by the DON/Nurse Educator. b.) Restorative Manager and/or designee to random audit 10 residents with intervention to offload pressure to heels for compliance weekly X 4 weeks and monthly thereafter with re-education as necessary by Restorative Manager. c.) Findings will be reported monthly by the DON/designee to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	3/23/12 3/30/12 4/08/12 4/08/12 4/08/12

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F 314	Continued From page 12 site..." Medical record review of a Treatment Administration Record (TAR) dated February 2012, revealed " ...DTI (Deep Tissue Injury) R (right) outer heel..." Medical record review of the Interdisciplinary Care Plan dated February 7, 2012, revealed "...float heels in bed..." Medical record review of a Nurse's Note dated February 8, 2012, at 6:37 p.m., revealed "...Area 1: right outer heel...onset/discovery date: 02/08/2012...wound type: blister...new area...width 2.5..." Medical record review of a Nurse's Note dated February 9, 2012, at 7:33 a.m., revealed "...Weekly Skin Assessment: Reddened area on buttocks..." (no assessment of heels) Medical record review of a Nurses's Note dated February 14, 2012, revealed "...right outer heel unstageable-deep tissue..." Medical record review of the March 2012 Physician Recapitulation Orders revealed "...DTI (deep tissue injury) Outer Heel - Apply Sure Prep bid (twice daily)..." Medical record review of a TAR dated March 2012, revealed "...Stage II (two) (R) (right) heel..." Medical record review of a Nurse's Note dated March 6, 2012, at 4:22 p.m., revealed "...right outer heel...drying blister...becoming smaller...length:1...width:2..."	F 314		

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F 314	Continued From page 13 Review of facility policy, Skin Ulceration Management Policy, revealed "...heel protector...wound will be assessed at least weekly..." Observation on March 5, 2012, at 3:30 p.m., in the resident's room revealed the resident lying on the bed with heels not floated or heel protectors in place. Observation on March 7, 2012, at 8:02 a.m., in the resident's room, revealed the resident lying on the bed with socks on heels not floated or heel protectors in place. Observation on March 7, 2012, at 8:49 a.m., in the resident's room, with Licensed Practical Nurse (LPN) #1 and C-Wing Assistant Director of Nursing (ADON) revealed a pressure ulcer to the right outer heel measuring 2.3 cm (centimeter) x (times) 2.7 cm no drainage. Observation on March 7, 2012, at 3:09 p.m., in the resident's room, revealed the resident lying on the bed without the heels floated. Interview with Certified Nurse Aide (CNA) #1 on March 7, 2012, at 3:11 p.m., in the resident's room, confirmed the resident did not have the heels floated and was unable to find the heel protectors in the room. Interview with the Director of Nursing (DON) on March 7, 2012, at 4:35 p.m., in the DON office, confirmed the resident was admitted on January 20, 2012, without a pressure ulcer to the right heel. Further interview with the DON on March 7,	F 314		

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F 314	Continued From page 14 2012, confirmed the resident was at high risk for developing pressure ulcers, no weekly skin assessments had been completed addressing the heels since admission, the pressure ulcer was identified on February 8, 2012, and the intervention to float the heels or wear the heel protectors had not been consistently implemented.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility staff failed to check the placement of a feeding tube for one (#107) of one resident reviewed with a feeding tube, of thirty-six residents reviewed. The findings included: Resident #107 was admitted to the facility on July 28, 2011, with diagnoses including Cerebrovascular Accident with Right Hemiparesis, Dysphagia, Aphasia, Hypertension, Diabetes, Erosive Esophagitis, and Prostate Cancer.	F 322	**1. Corrective action for residents affected:** Enteral tube of resident #107 checked for placement by nursing. **2. Identification of others who could be affected by the deficient practice:** Placement of enteral tube verified on all resident's receiving medications per tube by nursing on 3/07/12. **3. Measures put in place to ensure deficient practice does not reoccur:** The Nurse Educator completed education to nursing on enteral tube policy and procedure on 3/23/12, new staff to be educated during the orientation process.	3/06/12 3/07/12 3/23/12

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F 322	Continued From page 15 Observation on March 6, 2012, at 7:35 p.m., revealed the resident lying on the bed with the head of the bed elevated. Continued observation revealed LPN (Licensed Practical Nurse) #3 flushed the feeding tube with 30cc (cubic centimeter) of water and administered the medications, without checking the placement of the feeding tube. Review of the facility's policy, Medication Administration-Performance Phase (for residents receiving tube feeding), revealed "...Make sure the HOB (head of bed) is elevated to 45 degrees...using catheter tip barrel syringe, inset 30cc of air into the tube and auscultate over abdominal area for a 'whooshing' or 'bubbling' sound to confirm placement..." Interview on March 6, 2012, at 7:45 p.m., with LPN #3, in the hallway, confirmed the placement of the feeding tube was not checked prior to the administration of water and medication.	F 322	**4. Systems to monitor the effectiveness:** a.) Unit Managers/Team Leaders to audit medication administration via enteral route on 2 residents weekly for 4 weeks, then monthly thereafter with re-education as needed by the Unit Manager/Team Leader. **b.)** Findings will be reported monthly by the Unit Managers/Team leaders to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	4/08/12 4/08/12
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a hot	F 323	**1. Corrective action for residents affected:** a.) Hot pack removed from resident # 88 by nursing on 3/01/12. b.) MD notified of incident by nursing and treatment ordered. **2. Identification of others who could be affected by the deficient practice:** All residents have the potential to be affected by this practice.	3/01/12 3/01/12

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F 323	Continued From page 16 pack was applied correctly resulting in a burn (Harm) for one resident (#88) of thirty-six residents reviewed. The findings included: Resident #88 was admitted to the facility on February 1, 2012, with diagnoses including Cerebrovascular Accident, Urinary Tract Infection, Atrial Fibrillation. Medical record review of a Nurse's Note dated March 1, 2012, at 4:15 p.m., revealed "...burn...cause: hot pack had been applied to shoulder areas..." Medical record review of a Physician's Order dated March 1, 2012, revealed "...Alleyvan (allevyan) (dressing) to (left) shoulder blade q (every) 3 days..." Review of an inservice completed and dated March 1, 2012, revealed "...Therapy staff will apply hotpacks...to residents/patients who request them for pain/discomfort...therapy staff will keep the hotpacks locked...therapy/nursing staff will ensure an order is written to perform this type of therapy service Nursing will not apply therapy hotpacks." Medical record review of a Nurse's Note dated March 2, 2012, revealed "...F/U (follow up) incident: burn 3 x 3 cm (centimeters)...Inserviced staff, counseled nurse..." Medical record review of a Nurse's Note dated March 3, 2012, revealed "...burn left shoulder area...blistering, dressing dry, no s/s	F 323	**3. Measures put in place to ensure deficient practice does not reoccur:** a.) Lock installed on hot pack storage in therapy gym by therapy staff on 3/01/12 with only therapy staff having unlocking capabilities. b.) The Nurse Educator completed an inservice to nursing and therapy staff on application of hot packs by therapist only and presence of order for such treatment on 3/05/12, new staff to be inserviced during the orientation period. **4. Systems to monitor the effectiveness:** a.) Hot pack storage unit to be audited 5 days weekly x4 weeks for presence of locking mechanism by Therapy staff. **b.)** Findings will be reported monthly by RSM to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	3/01/12 3/05/12 4/08/12 4/08/12

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F 323	Continued From page 17 (signs/symptoms) of infections, no odor..." Medical record review of a Nurse's Note dated March 5, 2012, revealed "...burn...large scabbed area on left shoulder from blister. Small...broken blister were small scab is formed is distal to the large area blister. No signs and symptoms of infection...pulled back dressing on left shoulder to observe areas, dressing clean, dry and intact..." Medical record review of a Skin Assessment dated March 6, 2012, revealed "...left shoulder blade...burn...wound tissue: greenish-yellow...surrounding tissue: reddened...2.5 (cm) x 1.6 (cm)..." Medical record review of a Physician's Order dated March 6, 2012, revealed "...D/C (discontinue) Allevyn to LU (left upper) back...Dry drsg (dressing) to L (left) shoulder blade daily (and) PRN (as needed)..." Medical record review of a Physician's Progress note dated March 7, 2012, revealed "...discussed wound (with) staff. Appears to be partial thickness burn. Measurements per wound care agree (with) treatment (no) infection..." Medical record review of a Physician's Order dated March 7, 2012, revealed "...D/C current treatment orders to shoulder. Apply silvadene and dressing to L shoulder daily..." Observation and interview with a Licensed Practical Nurse (LPN) #1 on March 8, 2012, at 8:15 a.m., revealed a burn to the left shoulder, superficial, with no drainage or odor, and redness around the edges of the burn.	F 323		

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F 323	Continued From page 18 Interview by telephone with Registered Nurse (RN) #1 on March 7, 2012, at 2:20 p.m., confirmed RN #1 was the nurse who applied the hot pack and stated "...the resident was having shoulder pain, I got the hot pack and put on...shoulder...left the hot pack on for approximately 15 minutes..." Interview with the Director of Nursing (DON) on March 7, 2012, at 2:30 p.m., in the conference room, confirmed application of the hot pack resulted in a burn requiring treatment. Interview with a Physical Therapy Assistant (PTA) #1 on March 7, 2012, at 3:00 p.m., in the Therapy Department confirmed "...the hot pack required four layers of covering and the (nurse) didn't have the hot pack wrapped correctly..."	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425	**1. Corrective action for residents affected:** Medication cart audited by DON for presence of all current meds of resident #64 and found to be compliant. **2. Identification of others who could be affected by the deficient practice:** All residents with MD orders for pain medications have the potential to be affected by this practice. Medication cart audit completed for in house presence of all ordered pain medication by DON and found to be compliant.	3/08/12 3/08/12

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F 425	Continued From page 19 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a medication (MS Contin 45mg) was available for administration as prescribed by the physician for one (#64) of thirty-six residents reviewed. The findings included: Resident # 64 was admitted to the facility on December 14, 2011, with diagnoses including Pancreatic Cancer, Chronic Pain and Palliative Care needs. Medical record review of the January and February 2012, Physician's Orders revealed an order for MS Contin (pain medication) 45mg CR (continuous release), by mouth BID (twice a day). Medical record review of the January 2012, Medication Administration Record (MAR),revealed MS Contin 45mg CR was unavailable for administration for one dose on January 16, 2012, at 8:00 p.m. Medical record review of the February 2012, MAR revealed MS Contin 45mg CR, was unavailable for administration on February 9, 2012, at 8:00 p.m. Interview with the ADON (Assistant Director of	F 425	**3. Measures put in place to ensure deficient practice does not reoccur:** **a.)** In-service provided to nursing staff by Nurse Educator regarding telephone notification of pharmacy of new narcotic orders completed on 3/23/12, new staff to be inserviced during the orientation process. **b.)** In-service provided to nursing staff by Nurse Educator regarding MD notification of unavailable medications and obtaining order for therapeutic alternative available in emergency facility meds completed on 3/23/12, new staff to be inserviced during the orientation process. **4. Systems to monitor the effectiveness:** a.) DON/designee to review all new narcotic orders during daily clinical meeting. **b.)** DON/designee to review 24 hour report during daily clinical meeting. **c.)** Findings will be reported monthly by the DON to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	3/23/12 3/23/12 4/08/12 4/08/12 4/08/12

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	445235	A. BUILDING _____ B. WING _____	03/08/2012

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F 425	Continued From page 20 Nursing), in the Dining Room, on March 7, 2012, at 10:24 a.m., confirmed the prescribed dose of MS Contin 45 mg was not available for scheduled medication administration on January 16, 2012, at 8:00 p.m. and on February 9, 2012, at 8:00 p.m.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	**1. Corrective action for residents affected:** a.) Cx swabs in A/B med room discarded by nursing. 3/08/12 b.) Cx swabs in C med room discarded by nursing 3/08/12 c.) Unlabeled inhalers discarded by nursing. 3/08/12 **2. Identification of others who could be affected by the deficient practice:** a.) All residents have the potential to be affected by this practice. b.) Both med rooms and all med carts were audited for expired and correct labeling of medications and/or supplies by nursing and found to be compliant. 3/09/12 **3. Measures put in place to ensure deficient practice does not reoccur:** The nurse educator completed an inservice to nursing staff and central supplies coordinator on continuous audit of medication and supplies for expiration date and correct labeling on 3/23/12, new staff to be inserviced during the orientation process. 3/23/12	

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F 431	Continued From page 21 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were labeled according to Federal and State labeling requirements and accepted standard of practice, and failed to discard expired laboratory supplies in two of two medication rooms. The findings included: Observation on March 8, 2012, at 10:35 a.m., with Licensed Practical Nurse (LPN) #2 in the A/B Wing Medication Room revealed six culture swabs dated February 2012. Interview with LPN #2 on March 8, 2012, at 10:35 a.m., in the A/B Wing Medication Room, confirmed the culture swabs had expired February 2012, and were available for resident use. Observation on March 8, 2012, at 10:45 a.m., with the Director of Nursing (DON), in the C Wing Medication Room, revealed three culture swabs dated June 2011. Interview with the DON on March 8, 2012, at 10:45 a.m., in the C Wing Medication room, confirmed the culture swabs had expired June 2011 and were available for resident use. Observation on March 8, 2012, at 1:32 p.m., of	F 431	**4. Systems to monitor the effectiveness:** a.) Central Supply Coordinator to audit med rooms every other week x2 months, and then monthly thereafter for compliance with re-education as needed by Nurse Educator. **b.)** Unit managers/Team Leaders to audit med carts every other week x2 months, then monthly thereafter for compliance with re-education as needed by Unit Manager/Team Leader. **c.)** Findings will be reported monthly by the Unit Managers/Team Leaders and Central Supply Coordinator to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	4/08/12 4/08/12 4/08/12

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F 431	Continued From page 22 medication cart A with LPN #2 revealed a Pro Air HFA hand held inhaler not individually labeled and two Ventolin HFA hand held inhalers not individually labeled. Interview with LPN #2 on March 8, 2012, at 1:32 p.m., at the C Wing Nurse's Station confirmed the three hand held inhalers were not labeled identifying the resident's name, medication name, strength, expiration date, and instructions for safe administration. Interview with the DON on March 8, 2012, at 1:40 p.m., in the DON office, confirmed the three inhalers were not labeled properly and the facility had failed to follow the accepted standard of practice for medication labeling.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	**1. Corrective action for residents affected:** Nurse #3 in-serviced regarding standard precautions and use of PPE by Nurse Educator. **2. Identification of others who could be affected by the deficient practice:** All residents have the potential to be affected by this practice. **3. Measures put in place to ensure deficient practice does not reoccur:** The nurse educator completed an inservice to nursing staff regarding infection control and standard precautions on 3/23/12, new staff to be inserviced during orientation process.	3/06/12 3/23/12

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F 441	Continued From page 23 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow infection control practices for one (#85) resident of thirty-six residents reviewed. The findings included: Observation on March 6, 2012, at 7:56 p.m., revealed Licensed Practical Nurse (LPN) #3 performed a fingerstick to resident #85 without wearing gloves. Continued observation revealed LPN #3 returned to the medication cart, used hand sanitizer, prepared an Insulin injection and returned to the resident's room, and without wearing gloves administered the insulin injection to the resident.	F 441	**4. Systems to monitor the effectiveness:** a.) Nurse Educator or designee to complete random audits of nursing staff for use of PPE per policy 4x/week x1 month and then monthly thereafter with re-education as needed by Nurse Educator. b.) Findings will be reported monthly by the Nurse Educator/Designee to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	4/08/12 4/08/12

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F 441	Continued From page 24 Review of facility policy, Blood Glucose Monitoring, revealed "...wear gloves in accordance with standard precautions..." Interview on March 6, 2012, at 8:10 p.m., with LPN #3, in the nursing station, confirmed gloves were not worn when the fingerstick was performed and when the insulin injection was administered. Interview on March 7, 2012, at 8:50 a.m., with the Director of Nursing, in the conference room, revealed gloves were to be worn as standard precautions when performing a finger stick or administering injections to prevent the transmission of infection.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record	F 514	**1. Corrective action for residents affected:** Resident #30 02 Saturation obtained and documented by nursing. **2. Identification of others who could be affected by the deficient practice:** All residents receiving O2 therapy have the potential to be affected. **3. Measures put in place to ensure deficient practice does not reoccur:** a.) The nurse educator completed an inservice of nursing staff on 02 therapy documentation on 3/23/12, new staff to be educated during the orientation process. b.) All orders to check and document 02 saturation qshift were reviewed for accurate input into electronic charting system with any input errors corrected by Nurse Educator.	3/07/12 3/23/12 3/08/12

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F 514	Continued From page 25 was complete for two residents (#30, #51) of thirty-six residents reviewed. The findings included: Resident #30 was admitted to the facility on March 20, 2006, with diagnoses including Dementia, Hemiplegia, Cerebrovascular Accident, Pick's Disease, and Alzheimer's Disease. Medical record review of a Physician's Telephone Order dated February 27, 2012, revealed "...Check O2 (oxygen) Saturation q (every) shift AM PM..." Medical record review of the Medication Administration Record dated February 2012 and March 2012, revealed no documentation of O2 saturations for the PM shift. Interview with the Assistant direvtor of Nursing (ADON) on March 7, 2012, at 2:43 p.m., in the Director of Nursing's (DON) office, confirmed the facility failed to obtain Oxygen saturations for the resident on the PM shift. Resident #51 was readmitted to the facility on January 12, 2012, with diagnoses including Dementia, Atrial Fibrillation, Pneumonia, Anemia, and Open Wound. Medical record review of the Physician's Recapitulation Orders dated March 2012, revealed "...Check O2 Saturation q shift AM PM first date: 01/25/2012 (for shortness of breath)..." Medical record review of the Medication	F 514	**4. Systems to monitor the effectiveness:** a.) Unit managers/team leaders to audit 02 saturation documentation on 4 residents weekly x4weeks and then 4 residents monthly thereafter with re-education as needed by Unit Manager/Team Leader. b.) Physician orders for oxygen therapy to be reviewed by the DON during clinical meetings for accuracy of order input within ECS. c.) Findings will be reported monthly by Unit managers/team leaders and the DON to the QA Committee: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, Admissions Coordinator, and Business Office Manager.	4/08/12 4/08/12 4/08/12

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F 514	Continued From page 26 Administration Records dated January 2012, February 2012, and March 2012, revealed one PM O2 Saturation documented on February 8, 2012. Interview with the ADON on March 7, 2012, at 2:43 p.m., in the DON office, confirmed the facility only documented one O2 Saturation and failed to document forty-one O2 Saturations from January 25, 2012 through March 6, 2012.	F 514		